



## NC DMA Pharmacy Request for Prior Approval - Incivek/Victrelis

### Recipient Information

DMA-3486

1. Recipient Last Name: \_\_\_\_\_ 2. First Name: \_\_\_\_\_  
3. Recipient ID #: \_\_\_\_\_ 4. Recipient Date of Birth: \_\_\_\_\_ 5. Recipient Gender: \_\_\_\_\_

### Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

### Prescriber Information

7. Prescribing Provider #: \_\_\_\_\_ NPI: ☐ or Atypical: ☐

8. Prescriber DEA #: \_\_\_\_\_

### Requester Contact Information

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Ext: \_\_\_\_\_

### Drug Information

9. Drug Name: ☐ Incivek ☐ Victrelis 10. Strength: \_\_\_\_\_ 11. Quantity Per 30 Days: \_\_\_\_\_  
12. Length of Therapy (in weeks): Incivek: ☐ 12 ☐ Other: \_\_\_\_\_ Victrelis: ☐ 36 ☐ 44 ☐ Other: \_\_\_\_\_

### Clinical Information

#### For Incivek

1. Is the beneficiary 18 years of age or older? ☐ Yes ☐ No  
2. Does the beneficiary have a confirmed diagnosis of HCV with genotype 1? ☐ Yes ☐ No  
3. Is the beneficiary currently on ribavirin and peginterferon? ☐ Yes ☐ No  
4. Does the beneficiary have previous HCV NS3/4A protease inhibitor treatment for Hepatitis C? ☐ Yes ☐ No

#### For Victrelis

5. Is the beneficiary 18 years of age or older? ☐ Yes ☐ No  
6. Does the beneficiary have a confirmed diagnosis of HCV with genotype 1? ☐ Yes ☐ No  
7. Does the beneficiary have at least 4 weeks of prior therapy with ribavirin and peginterferon? ☐ Yes ☐ No  
8. Is the beneficiary currently on ribavirin and peginterferon? ☐ Yes ☐ No  
9. Does the beneficiary have previous HCV NS3/4A protease inhibitor treatment for Hepatitis C? ☐ Yes ☐ No  
10. Does the beneficiary have a diagnosis of Cirrhosis? ☐ Yes ☐ No  
11. Is the beneficiary a non-responder to previous treatment with peginterferon and ribavirin? ☐ Yes ☐ No  
12. Has the beneficiary had a poor response to interferon? ☐ Yes ☐ No

Signature of Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_

**\*Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSC at: (855) 710-1964

Pharmacy PA Call Center: (866) 246-8505

Instructions for completing this form can be found at <http://www.NCTracks.com/PAformhelp>

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